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ORIGINAL LECTURES.

CLINICAL LECTURE ON DYSPNEA AS A SYMPTOM OF INTRATHORACIC PRESSURE.

Delivered in Philadelphia Hospital, October 4, 1879,

BY EDWARD T. BRUEN, M.D.,

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GENTLEMEN—The specimens I lay before you this morning were taken from the patient whose case we considered two weeks ago, and decided to be aneurism of the aorta.

In the week ensuing that clinic the paroxysms became so violent that great exhaustion followed, and his strength was rapidly wasted.

Last Wednesday, October 1, he experienced an unusually severe paroxysm. Atropia was used, as before, to stimulate respiration, but failed to relieve him. The inhalation of ether was tried, with the hope of relaxing the spasm of the bronchial tubes, but he did not rally as before, and died at the expiration of two hours, from asphyxia.

Examining the aorta, a globular tumor, as large as a goose-egg, arises from the upper portion of the right side of the ascending arch of the aorta. This tumor, by growing outwardly, gave rise to the prominence I demonstrated to you during life, but, as you will observe, this tumor did not compress any of the important structures within the chest. From the posterior aspect of the ascending arch another tumor, similar in size and shape, was found. The tumor extended backward until it touched the bodies of the vertebrae, pressing inward the trachea, and decidedly diminishing its calibre just above the point of the bronchial bifurcation. The tumor was also adherent to the right bronchial tube which leads to the inferior lobe, almost occluding its lumen. The union between the tissues of the two structures is so intimate that I cannot separate them. The inferior portion of the lower lobe of the right lung is collapsed and splenified; the remaining portion of the pulmonary tissue is emphysematous, completely covering the splenified area. Passing over the inferior surface of the lower

tumor you can recognize the pneumogastric nerve, which was compressed between the tumor and the bodies of the vertebrae.

Let me at this point comment on the diagnosis as given last week, and on the specimens before us.

The collapse of the inferior lobe was not recognized during life, partly because of the emphysematous condition of the remainder of the lung, partly from the fact that the collapsed tissue was adherent by old pleuritic adhesions to the liver, and the convex surface of the upper portion of the organ favored its concealment.

It was owing to the apparent absence of this very lesion that I did not believe so much bronchial pressure as we have found could exist.

The constant dyspnea, then, we must refer to the bronchial and tracheal pressure; but the sudden arrest of respiration in particular, and a portion of the dyspnea, are to be referred, I believe, to the pressure which we discover in the pneumogastric nerve. The attacks of dyspnea were always inaugurated by arrest of respiration, and only subsequently were the violent respiratory efforts noticed.

Let us look again at the tumors. We observe that they are very hard, solid, and, on opening the heart and introducing the finger into them, they are found almost filled with organized fibrine: so that but little blood could have entered them. You will recall that no thrill was noted, and but a comparatively feeble systolic murmur. The absence of these physical signs is now clear, since no blood could have entered the tumors.

The increase of murmur by pressure on the tumor is explained by the fact that such pressure diminished the calibre of the aorta. We have a familiar illustration of this point by the development of a murmur from the pressure of a stethoscope upon the femoral artery. I would suggest that this is a point to be observed in connection with the diagnosis of the state of the contents of aortic aneurisms.

If we had been able to satisfy ourselves that the tumor was already solidified, the operation of electrolysis would have been considered positively contra-indicated. For the futility of this operation in this case is evident, nature having accomplished the result for which we should have labored.

Indeed, I fear the use of electricity might have resulted in actual mischief, by disorganizing the clot already formed. If in a future case I shall discover a similar series of symptoms, I shall consider the evidence to indicate an aneurism filled more or less with an organized clot.

The interference with the lumen of the vessels at their origin from the aortic arch partially indicates the explanation of the femoral pulse antedating the radial.

The heart, you will note, is not hypertrophied, nor are the vessels or aorta atheromatous. The other viscera are normal. Had our patient survived the paroxysm, life would sooner or later have terminated through the rupture of the inferior aneurism into the bronchial tubes or trachea.

As a general principle which should regulate the consideration of the operation of electrolysis, I think we have a right to infer that symptoms of serious intrathoracic pressure contra-indicate the measure.

Case II.—Let us turn to the consideration of the patient whom I now introduce. You all notice that he, too, suffers marked dyspnoea, attended with stupor and whistling respiration. The dyspnoea is so intense that at present he cannot walk up- or down-stairs without becoming excessively short of breath. The supraclavicular regions are depressed on inspiration, in addition to the stridulous breathing; evidently some obstruction exists in the larynx to the entrance of air. We are supported in this view when we ask the patient to speak, and, while phonation can be performed, the result is a thick, low-pitched, imperfect articulation or expression of sound.

When we inquire into the onset of these symptoms, our patient refers them all to a cold taken six weeks ago (the six weeks prior to his admission to the hospital). With this cold he lost his voice, and has felt a choking sensation referred to a point behind the sternal notch; he has also some cough.

From these symptoms we are led at once to make a laryngoscopic examination, and we find that both vocal cords are much swollen, are red, and that the left vocal cord seems partially paralyzed; at all events, it imperfectly approximates itself to the other. At the same time the cords open and close freely, and there can be no question that an obstruction lower

down the air-passages must exist to account for the dyspnoea present.

Let me read to you some points in the history of the case:

A. C., *aet. 40*, has a good family history; denies syphilis or the immoderate use of alcohol. He has always enjoyed excellent health, save only occasional attacks of rheumatism. He suffered much exposure while a member of the Army of the Potomac, and when making forced marches, at that time, he occasionally became short of breath. At the close of the war he resumed his trade as a painter.

In view of the symptoms detailed, and the history, let me ask the class for a suggestion as to the cause of pressure.

A member responds, "Cancer of the oesophagus."

It is true that cancers of the oesophagus are most frequent at the point of the bronchial bifurcation, and may cause analogous symptoms of pressure. But in the first place the onset of the symptoms present in this case is recent; there is no dysphagia, no pain, no cancerous cachexia; indeed, our patient is fairly nourished.

Can I elicit any evidence of pressure on the bronchial tubes? Percussion-resonance is high-pitched over the right side, especially at the base of the right lung, as compared with the left. On the other hand, the respiratory murmur is impaired over both lungs posteriorly, and on the left side, in addition, inspiration is attended by sonorous, sibilant, and a few small mucous râles. The respiration over the right bronchus, at the point of bifurcation, is whistling, much louder than normal. On the other hand, the respiratory murmur in the left bronchus is much more feeble than normal. These physical signs indicate pressure on the bronchial tubes, and, when we recall the condition of the inferior lobes of the lung in the specimen you have just seen, does it not indicate a similar state of affairs in this case?

We find in the groin several enlarged glands, and elsewhere a few can be felt. I have read of cases in which symptoms similar to those exhibited by our patient could be traced to an enlargement of the bronchial and mediastinal glands, causing pressure. But we have in this case no syphilis, none of the forms of leucocytæmia; and therefore, while recognizing the suggestion as a possible explanation, I decide that it is improbable.

A gentleman desires an examination of the aorta. Let me comply by stating that a systolic murmur can be heard over the base of the heart and at the ensiform cartilage transmitted into the carotids, but diminished as a murmur over the arch of the aorta, and becoming merely a harsh prolongation of the first sound, at the same time distinctly audible. There is no mitral lesion; no abnormal dulness over the aortic arch; no pulsation; no thrill. The cardiac dulness extends to the right a little beyond the right costo-sternal articulations, but dulness to the left is within a vertical line drawn from the nipple. The apex-beat is felt in the sixth interspace a half-inch inside the nipple-line; there is epigastric pulsation, evidently cardiac. The heart must therefore be considered as displaced, but not much enlarged. The radial pulses, however, you will note, precede the femoral,—just the reverse of the former case, and indicating aneurism at a point below the descending arch of the aorta.

Posteriorly at the left side, just above the angle of the scapula, can be heard a murmur, also systolic, and even more distinct than the murmur at the base. It is low-pitched and blowing, transmitted a short distance up and down the aorta, but not heard in the femorals.

Let us now sum up the points we have elicited for or against aneurism of the descending thoracic aorta at the bifurcation of the bronchial tubes.

There is no pain. Pain may be induced by the pressure of the tumor on the intercostal nerves, and also on the vertebral column itself, for the pressure may be so great as to occasion necrosis. Our patient complains of but slight pain. In a case in Dr. Pepper's ward, a week ago, a diagnosis of aneurism of the descending aorta was made by him, in which the symptom of pain was absent, and the post-mortem showed extensive caries of the vertebrae. We have tested this man without response, both by means of the electrical test of Rosenthal,—which acts by arousing sensations of pain when the electricity is passed over diseased bone,—and also by means of the hot and cold sponges passed over the spine, designed to act on the nerves which issue from the spinal foramina; these nerves are hypersensitive in caries of the spine.

There is no dysphagia, but I have seen

aneurism at this point compress the bronchial tubes and yet not affect the oesophagus. There is no thrill, and the murmur heard is not loud, although distinct. There is no specific history, nor the habit of alcoholic indulgence.

The presence of a murmur, the radial pulse antedating the femoral, the cardiac displacement, the presence of symptoms of bronchial compression, with the absence of all other modes of explanation of the symptoms, are the evidences of the aneurism. I think the life of exposure in the army, the forced marches, are not to be overlooked, and I distrust his statements about specific disease and alcoholism.

Favorable points for the diagnosis are as follows: there is relief from the dyspnoea by change of position; sometimes the ease is greater in the upright, sometimes in the recumbent posture.

A portion of the dyspnoea is, doubtless, laryngeal, due to the causes I have described, but I believe that the symptom is due, in the main, to aneurism of the descending arch of the aorta, with pressure on the bronchi. You will note that in this case of purely bronchial pressure the symptoms in the last case, which I referred to pressure on the pneumogastric nerve, are absent.

The prognosis is grave. In a case you saw about two weeks ago, rupture took place into the bronchial tube, attended by haemoptysis, four weeks before the death of the patient. Very often, at first, but a small rupture occurs, and its enlargement may take place so gradually that some time may elapse before fatal hemorrhages ensue.

The danger of rupture, then, of similar aneurisms of the aorta causes our liveliest apprehension, and yet the patient may survive for several years before this accident occurs. The treatment is simple. It involves absolute rest, a diet from which liquids should be excluded as far as possible, and the administration of the iodide of potassium on the plan of Dr. Balfour. This gentleman says that no other salt of potassium will answer so well. He advises large doses, as much as ninety grains per diem. He claims that it produces diminished cardiac force and diminished blood-pressure, and decreases the size of the sac by thickening of its walls, mainly the adventitia.

Dr. Balfour states that he has cured some cases by this means alone, without the recumbent position. We shall order our

patient large doses of iodide of potassium, to secure an increase of the laryngeal secretions, as well as for its effect on the aneurism itself. I may say that by counter-irritating the tissues below the external laryngeal region by blisters I have secured a great amelioration of the laryngeal symptoms. In addition to this, the occasional application of nitrate of silver has been practised; also the inhalation of a solution of compound tincture of benzoin.

I trust that the pictures of these two cases may not fade from your minds, and that you will always recall them when you meet with cases of dyspnoea from intrathoracic pressure.

ORIGINAL COMMUNICATIONS.

A CASE OF DOUBLE VAGINA AND CERVIX UTERI.

BY WM. R. D. BLACKWOOD, M.D.,

ON the 10th of October, 1878, I was consulted by Miss —, aged 22, with the appearance of robust health, for relief from a distressing headache, frontal in situation, moderate in intensity in the early morning, with increasing severity towards evening, at which time it usually disappeared, although occasionally the malady would continue far into the night, with the effect of banishing sleep till nearly break of day. In addition, she endured pain of varying force, indefinitely ascribed to the left hypogastric region. I say indefinitely, because it rarely for an hour at a time was constant at any one definite point. After being under my charge for some weeks, it became apparent that the difficulty was most probably located in or near the left ovary, which was more than usually tender upon pressure, and more than ordinarily movable through manipulation, although, left to itself, no tendency to downward displacement existed, as might, under the circumstances, have been expected.

Upon commencing a digital vaginal investigation, the first noticeable point was the unusually firm hymen, with, as proved by ocular demonstration, two openings therein. By careful, slowly-made, and gentle effort the left opening was dilated sufficiently to permit the finger to reach the cervix uteri, which at once gave evidence of abnormal development, being sharply latero-flexed. Conjoined manipulation by the rectum proved that no displacement of the body of the uterus was present, and this led to a more careful procedure, the result of which developed the fact that each of the openings in the hymen entered vaginae of their own. So far the case was one of double vagina. The time and pain prevented

further investigation until next day, when a thorough dilatation of both cavities was made and a speculum examination begun. Each vagina was such as is found in the virgin, moderately capacious, and presenting no abnormal features. The cervix on the right side presented at an angle of about ten degrees, bending towards the right, and that of the left side made an angle of probably twenty degrees, pointing towards the left. Each cervix was normal in shape, size, and general characteristics, both canals patent to the sound, but only so as far as the os internum, beyond which, passage at this time was impossible with any justifiable force. Conjoined manipulation by both the rectal and abdominal parietes showed the uterus to be single, with double cervix. The body of the uterus was of the usual size, and was freely movable and not sensitive to pressure. No uterine catarrh existed; the organ was evidently sound. At the third examination, which occurred after an interval of three days, the right cervical canal was dilated instrumentally, and the sound passed to the fundus, the length being two and a half inches. The other cervix gave more trouble, but through careful and gentle manipulation the sound entered to a distance of two and three-quarter inches, the extra distance being clearly attributable to the lengthening of the cervix. There was a palpable difference in the feeling of the two sides of the cavity of the uterus after passing the internal os, a distinct elasticity or softness being experienced in the central line, the reason for which became apparent on introducing a sound into each cavity simultaneously. The uterus was divided into two cavities by a vertical septum, which is undoubtedly complete, no manœuvre allowing the sounds to touch each other through any discoverable opening. The case was thus shown to be one of *uterus septus*, the septum being prolonged to the ostium *vaginæ*. All other organs were apparently normal in position and action. It was determined to divide the vaginal septum. To obviate troublesome hemorrhage, the elastic ligature was resorted to. About one inch of tissue was included in the loop, which cut its way out in four days without much discomfort. The next time two inches were similarly treated, and the section was made as before in four days, the ligature requiring tightening on the second day. A third application severed another inch, leaving about one inch remaining between the right and the left cervix. The idea of severing the intra-uterine septum also was entertained, but because of the thickness of the triangular mass of tissue between the two os uteri the operation was postponed, and nothing in that direction has yet been attempted.

In the general examination of the case I had elicited the fact that the pain which accompanied menstruation and was referred to the left side was intensified at every second

menstrual period, and, although in every other respect no discomfort was experienced, there seemed here to be an implication of the left ovary; in fact, it was from this idea that the physical examination during the menstrual flow was suggested. The period in progress was the one in which the pain was not increased during the flow. The first point which interested me was, that the discomfort of the left side was less than it had been before menstruation set in, and that pressure was better borne, yet on the *right* side (over the ovary) firm pressure produced uneasiness to a greater degree than before the period. The thought occurred to me that possibly the congestion incident to ovulation might be confined to one only of the ovaries, and if such was the case, what effect, if any, would this have in the peculiar condition of the uterus? On very careful speculum examination, the fact became apparent that *the flow was entirely confined to the right side of the uterus*. That every possible source of error should be excluded, I prolonged the examination for half an hour, after which time other engagements prevented further observation till the next day. On the succeeding afternoon I repeated the investigation, with precisely the same result, and, as the flow was much less abundant, the difficulty of keeping the parts clean was not so great as before. The small portion of the vaginal septum remaining permitted the plugging of the left Douglas cul-de-sac readily, and after retaining a tampon of absorbent cotton therein for half an hour not a particle of blood had been extruded from the uterine cavity of that side. Similar results were obtained on the next day, the last of that period. For a day or two the lessened pain in the left side continued; it then recurred, however, and persisted until the next term ensued, when the trouble was intensified, as was habitual. Nothing of a surgical nature had been done in the interval, the only attention having been for the relief of the headache, which persisted, however, in spite of all that was done. On the appearance of the catamenia the specular examination was renewed. *The flow was now from the left cervix alone*. As before, care was had to exclude possible error, and during the three days ensuing the only difference observable was that the amount of discharge was less than had been observed from the right side, and some little pain was present during the first twenty-four hours. The present month has been the thirteenth since my inquiries began, and in these thirteen periods the regular alternation has been maintained, with a single exception,—that in August, when the flow should have been *right-sided*, it was from the *left*, as in the month before.

Remarks.—The physiology of menstruation is not by any means thoroughly understood. Wide differences of opinion are held by eminent authorities on this subject,

and it will doubtless require much study and research to unravel the hidden secrets of this exceedingly interesting branch of medical learning, and anything bearing upon the subject is therefore of right the property of the profession at large. The difficulty in accounting for congestion on one side only of a uterus divided simply by a septum of probably a quarter of an inch in thickness is hard to meet, and no explanation is attempted. That the excitation of the body of the uterus in this instance is thus confined is beyond question in my mind, for I cannot conceive of the hyperæmia existing in each lateral half without the outpour of blood from each section. What the arterial and venous distribution is cannot, of course, be here determined, but it must certainly be abnormal, or the septum must be of such a nature as to shut off communication between the sides by extending through the tissue of the organ to the peritoneal investment. Were the substance of the uterus bisected by a cartilaginous diaphragm, the enigma would at once be solved. If marriage in the case ensues (and I hope it will), and pregnancy occurs, the result will be very interesting; and it was largely from this line of probability that the portion of vaginal septum was allowed to remain, the idea suggesting itself that double pregnancy might take place at different periods. For a long time the headache and abdominal pain were apparently beyond relief; in fact, the latter was notably aggravated by the excitement kept up by frequently repeated examinations. Finally, however, electricity achieved an almost complete victory, and, from having to undergo daily treatment, the patient now often is for a fortnight free from trouble. It is probable that complete immunity will never be attained, owing to the physical peculiarities involved; but at any rate she is comparatively free from what had long been an inseparable companion.

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A NEW FUNCTION OF THE BRAIN —PRELIMINARY NOTE.

BY ISAAC OTT, M.D., AND G. B. WOOD
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THE influence of the nervous system on the peristaltic movements of the intestinal canal has been the subject of

several researches. The activity of the central nervous system to excite peristalsis has been noted by several observers, but the power of the brain to inhibit the intestinal movements has not been stated in any work accessible to us. That the splanchnics inhibit the intestinal movements was discovered by Pflüger,* and confirmed by several observers. Goth† has noted in the frog, after extirpation of the central nervous system, that the myenteric ganglia are more excitable. Wilson Philip‡ has also remarked that the movements of the intestines continue a long time after the removal of the cerebro-spinal axis.

Nasse§ has seen stimulation of the dorsal segment of the spinal cord arrest the intestinal movements. One of us, in another place, has proved that in the optic thalami reside centres inhibiting the reflex activity of both internal and external sphincter ani. This inhibition was found to be in constant activity. Now if, in an etherized cat, a section of the brain is made behind the thalami optici, it will be found that the duodenum soon commences to make an active peristaltic movement. Peristaltic movements in the carnivora, as the cat and the dog, are normally hardly anything at all. That this active peristalsis was not due to an excitation of centres inciting peristalsis is proved by a series of experiments on animals whose intestinal movements are active. Rabbits were etherized, and insulated electrodes thrust through trephined openings into the optic thalami. If now the peristalsis is noted of the duodenum, it will be seen to stop in diastole. So the inference follows that in the optic thalami are centres inhibiting not only the reflex activity of the sphincters ani, but also the activity of the small intestines. According to this view, the peristaltic movements are under the domination of two forces,—one exciting, and derived from the ganglia seated in the walls of the intestines and the ganglia of the central nervous system, the other inhibiting, seated in the thalami optici, and sending its impulses through the splanchnics.

* Ueber das Hemmungs-Nervensystem der Gedärme. Berlin, 1857.

† Pflüger's Archiv, 1872, S. 616.

‡ Souget's Nervensystem, Leipsic, 1847.

§ Journal of Physiology, vol. ii. part 1, Cambridge, 1879.

|| Beiträge zur Physiologie der Darmbewegung. Leipsic, 1866.

NOTES OF HOSPITAL PRACTICE.

UNIVERSITY HOSPITAL.

SERVICE OF PROF. LOUIS A. DUHRING, M.D.
SEBORRHŒA OF THE SCALP AND FACE.

THE patient is a married woman, 37 years of age, of fair general health. The present eruption first showed itself upon the scalp five years ago, appearing upon the face a little later. It has been gradually growing worse and worse ever since, but especially during the past few months. The disease has not progressed steadily, but by occasional exacerbations occurring every month or so with intervals, during which it seems to disappear almost entirely from the face, while on the scalp there always remains a slight degree of scaliness. The hair has always been very dry; there is no tendency to oiliness in the scalp. The face, on the other hand, has always been more or less oily, and seems to attract dust, so that it always presents a soiled appearance. If the patient wipes her face with her handkerchief, this becomes quite greasy. The face, moreover, as well as the scalp, is covered with greasy crusts and scales over the seat of the disease. Under ordinary circumstances the disease in the scalp manifests itself in the form of dry, branny scales, without any tendency to moisture or weeping. The skin here, however, is quite irritable, and now and then the irritation from rough combing alone is sufficient to excite an acute inflammatory action accompanied by a sticky, serous discharge. The scalp has always itched slightly, while on the face this symptom is not complained of, the sensation here being rather of a burning, smarting character. During the past few weeks the eruption has been rapidly growing worse. She has never had any other disease of the skin; her appetite is not very good, and the bowels tend to constipation; she suffers somewhat from indigestion, indicated chiefly by flatulence. When she eats food which disagrees with her, as salt fish, ham, etc., the face grows worse at once. She is decidedly nervous.

Dr. Duhring said he had brought this case before the class not because it was rare or even uncommon; on the contrary, it is a mild but typical case, and worthy of study on that account, in order that the essential features of the disease may be

come familiar; for it is oftentimes not easy to distinguish between this and other affections of similar appearance. On examination we perceive a patch of slightly-red-dened and infiltrated skin on each side of the cheek extending towards and including the alæ nasi, covered with somewhat adherent greasy scales, which, when detached, leave a slightly oily surface beneath, thickly studded with the patent openings of the sebaceous follicles. Proceeding to the examination of the scalp, we find this covered with minute branny scales, decidedly more abundant over the vertex. If we examine these scales more closely, we shall observe that while many are fine, dry, powdery, and loose, others are somewhat larger, unctuous or greasy, and tend to adhere to the integument underneath. When detached, these scales leave a reddish, glazed surface underneath. While the vertex is entirely covered with scales, we note that elsewhere over the scalp the eruption appears in scattered coin-sized patches. Seborrhœa does not everywhere present exactly the same features. We should not, for instance, expect to find the affection assuming the same appearance on the scalp, the face, and the shoulders. The normal size, number, and arrangement of the sebaceous glands are different in these several localities, and the disease naturally varies also. The character of the product of disease likewise varies in different cases. In some cases the sebum is dried and inspissated, while the epithelial element is prominent, and here we have the variety of seborrhœa known as seborrhœa sicca. In other instances the sebaceous product poured out is abnormally fluid, and we have that variety of the affection which is known as seborrhœa oleosa. Both of these varieties, moreover, may coexist in any given case: we may have, for example, seborrhœa sicca on the scalp while at the same time we have seborrhœa oleosa on the face.

The local varieties should also be studied carefully, viz., seborrhœa capitis, occurring on the scalp; seborrhœa faciei, on the nose and cheeks; seborrhœa corporis, on the body, as a rule either between the scapulae or over the sternum. Each of these possesses certain peculiarities which should be noted. In speaking of the varieties of seborrhœa, *S. neonatorum* must be mentioned. This is in fact rather a physiological than a pathological condi-

tion, and under ordinary circumstances tends to disappear within a few weeks after birth. Occasionally, however, it may persist for some months, but it is readily removed by appropriate treatment.

In connection with seborrhœa we are apt to meet with other affections of the sebaceous glandular system, as milium, molluscum, and comedo. As an instance of this let us observe this second case which I now bring before you. Here we have a young, unmarried woman, in rather delicate health, who presents precisely the same appearances upon the scalp as in the case of our first patient, only to a more extensive degree. But in addition to the seborrhœa sicca capitis we observe seborrhœa faciei, involving both temples, while scattered over the temples, sides of the neck, chest, and scapular region we see a large number of pin-head sized, hard, pearly nodules, which are nothing more than closed sebaceous ducts choked up with their contents, and forming the condition known as milium. Here and there, moreover, we see larger, small split-pea sized, more prominent, softer lesions, with a central depressed punctum, constituting imperfect examples of molluscum sebaceum. In addition, we see also a large number of plugged-up sebaceous glands with their black puncta, —comedones, forming a very good demonstration of the coexistence of four distinct diseases of the sebaceous glands.

With regard to the etiology of seborrhœa, this affection may attack all ages, both sexes, and every temperament. It is somewhat commoner, however, between the ages of sixteen and thirty, and in blondes. When the disease occurs in brunettes, it is more apt to assume the oily form, as the glands are more active in persons of this complexion. While seborrhœa is often found in the subjects of anaemia and chlorosis, yet we quite frequently find it in apparently perfectly healthy persons. Very often the digestive system, and particularly the alimentary canal, are at fault. In the present case, our patient has admitted that the ingestion of such articles as salt meats causes an exacerbation of the disease.

The pathology of seborrhœa may be inferred from its name: it is essentially a disease of the sebaceous glands, accompanied by hyperæmia and an increased secretion of more or less altered sebum. The course of the disease is sometimes acute,

but far more frequently chronic, dragging along for years,—sometimes better and sometimes worse. It is ordinarily better in summer and worse in winter.

The diagnosis of seborrhœa is occasionally, as has been said, a matter of some difficulty. It is to be distinguished from *eczema squamosum*, as this occurs upon the scalp, and from *psoriasis* affecting the same locality. The ordinarily greasy character of the scales, with the pale reddish, oily or glazed surface, with gaping gland ducts displayed when the scales are removed, together with the history of continual dryness without any discharge, will suffice to distinguish *seborrhœa capitis* from the two dry and scaly eruptions mentioned. When *seborrhœa* occurs upon the face it is to be distinguished from *lupus erythematosus* and *eczema erythematosum*, and here, especially as to the former disease, the diagnosis is often puzzling. It must be kept in mind, however, that while on the one hand there is merely a general and intense hyperæmia in *eczema*, we have on the other hand in *lupus erythematosus* a new cell infiltration, it may be very slight, accompanied generally by marked involvement of the glands, and usually followed eventually by atrophic scarring. *Seborrhœa faciei* often occupies as it were a middle place between these diseases, the glands indeed being seriously involved, but no new cell infiltration taking place and no scarring following. On the chest and back *seborrhœa corporis* is to be distinguished from *tinea circinata*, from *psoriasis*, and from *eczema*. But the same features—namely, the involvement of the glands and the more or less greasy or oleaginous character of the product of disease—which are noted in *seborrhœa* of the scalp and face serve likewise here to differentiate the disease in question from the other affections mentioned.

The treatment of *seborrhœa*, speaking in general terms, is both internal and external. The internal treatment will, of course, depend upon the nature of the individual case and the general condition of the patient. Ordinarily, iron, arsenic, cod-liver oil, and similar remedies are called for. Sulphur and the sulphides in small doses long continued have also recently been prescribed with benefit. Both of these cases will require a prolonged course of treatment, in which iron and small doses of arsenic will in all probability play the most prominent part. In

perhaps seven or eight cases out of ten the local treatment will prove of more importance than the constitutional. The sort of local treatment to be employed depends somewhat upon the locality of the disease. If it is in the scalp, the first thing to do is to get rid of the scales. Often it is necessary to soak the scalp with olive oil in order to soften the crusts and scales before we are able to wash these out. In the present instances this is not necessary, but we may apply the soap directly. The best kind of soap for washing the scalp in cases of *seborrhœa* is *sapo viridis*, a strong potash soap, used either alone or dissolved in alcohol, as in the solution which we know as *spiritus saponis alkalinus*, and which is composed of two parts of the soap to one part of stronger alcohol, and perfumed. When the patient is a woman, do not have the hair cut; do not disfigure her; it is not necessary to the treatment of the disease, for by using a little perseverance we can always remove the scales in any case, and once cut, the hair will probably never assume its former beauty or grow again to its original length. Tell your patient to make a thick lather with the soap or the spirit mixed with a small quantity of hot water, and with this shampoo the scalp thoroughly. Then let the scalp be completely cleansed with fresh warm water, and, after drying, apply some ointment. It is always necessary to employ an oleaginous application following the use of the soap; otherwise we should have a disagreeable contraction of the skin. Never use soap in this affection without following it with some ointment or oil. One of the best ointments to be used in *seborrhœa* is the preparation of petroleum known as *cosmoline* or *vaseline*. To this may be added with advantage some stimulant, as the red oxide of mercury, five to ten grains to the ounce; sulphur, a drachm to the ounce; and tar, of the same strength. In the present cases we shall use—

R Ung. hydrarg. nitrat., 3ij;

Vaselini, 3ij;

Adipis benzoat., 3iv;

Olei amygdalæ amaræ, gtt. iij.—M.

In using an ointment care should be taken to separate the hairs in "parts," so that the scalp is exposed. The ointment is then to be applied directly to the skin and rubbed in diligently. It is not the amount of ointment employed, but the degree of thoroughness with which it is

worked into the skin, which determines the benefit ensuing. An ointment of tannic acid, in the strength of half a drachm to a drachm to the ounce, applied once or twice daily, may be used with advantage in some cases; Dr. Bulkley, of New York, speaks well of it. Sulphur also is a valuable external application in seborrhœa; it may be prescribed combined with vaseline in varying proportions from fifteen grains to two drachms in the ounce. When for any reason it is undesirable to employ ointments, there are a number of oleaginous applications which may be prescribed with advantage. Such, for instance, is the following mixture, which can frequently be prescribed when ointments are inadmissible:

R Acidi carbolici, $\text{m}\ddot{\text{x}}$ ad xx;
Alcoholis, f $\ddot{\text{z}}$ i;
Ol. ricini, f $\ddot{\text{z}}$ ss ad 3i.—M.

Or the following, which is a somewhat more elegant preparation:

R Tinct. cantharidis, f $\ddot{\text{z}}$ ij;
Tinct. capsici,
Ol. ricini, $\text{a}\ddot{\text{a}}$ f $\ddot{\text{z}}$ ij;
Alcoholis, f $\ddot{\text{z}}$ ijss;
Sp. rosmarini, q.s. ad f $\ddot{\text{z}}$ iv.—M.

But, whatever preparation is employed, due care and perseverance must be used in its application, or it will be of no avail.

TRANSLATIONS.

A PECULIAR FORM OF MICROCOCCUS IN GONORRHOEA.—Dr. Albert Neisser (*Cbl. f. Med.*, 1879, No. 28) has detected, with the aid of very high powers, a peculiar organism in the gonorrhœal discharge, which is at first round, later, a long, oval body, which separates in the middle and divides by fissure, subdividing again at right angles so as to form a sarcina-like group. Twenty or thirty of these bodies are often united in a heap, covered with a sort of mucous envelope. Their favorite seat is upon the surface of the pus-corpuscles.

PHYSIOLOGICAL AND THERAPEUTICAL CHARACTERS OF THE ADONIS VERNALIS.—Botkin (*Cbl. f. Med.*, 1879, p. 493; from *Petersb. Med. Wochens.*) asserts that the infusion of this plant exerts a similar action to that of digitalis, regulating the cardiac compensation in some forms of its disturbance, even when digitalis fails.

COINCIDENCE OF TABES DORSALIS AND AORTIC INSUFFICIENCY.—Berger and Ro-

senbach (*Berliner Klin. Wochens.*, 1879, p. 402) bring forward seven cases of well-marked tabes accompanied by extreme insufficiency of the aortic valves. While saying that they are far from desiring to draw positive conclusions from their cases, Berger and Rosenbach call attention to the coincidence of these affections, and ask that further observations may be made, with the view of ascertaining whether or not any real connection may exist between the two affections.

SYPHILIS OF THE CENTRAL NERVOUS SYSTEM.—At a recent meeting of the Königsberg Association for Scientific Medicine (*Berliner Klin. Wochens.*, 1879, p. 407), Dr. Naunyn spoke upon this subject. Out of sixty cases to which he referred, where the history of the patients had been accurately noted, eight had been examined post mortem. No exostoses (which during life are so frequently set down as the cause of brain-symptoms in syphilis) were found. On the other hand, gummata in the brain substance, subdural gummata, softening as a sequela of endarteriitis, with or without consecutive thrombosis, and simple softening, were ascertained to be present. Brain syphilis frequently belongs to the earlier manifestations of the disease. Naunyn has frequently seen it within the first year. Heubner's assertion, that intellectual and particularly active men were peculiarly liable to this form of disease, does not appear to be borne out by Naunyn's experience. In general, it may be said that young persons are particularly liable to brain syphilis. That there are any specific peculiarities about the disease, excepting the paralysis of the ocular muscles and pain in the head, Naunyn cannot admit. The only characteristic point is that the usual symptoms occur in the young instead of the old. An important diagnostic point is the absence of symptoms pointing to compression (*stauungspapilla*, etc.). The usual symptoms are those pointing to a centre of disease; hemiplegia was common in Naunyn's cases, together with paralysis of the ocular muscles, in many instances, which, as is known, rarely occurs in ordinary hemiplegia. Epilepsy is not uncommon. Charcot's assertion that hemiplegia is particularly characteristic of syphilis is not borne out by Naunyn's experience. He has *never* seen a case. Paraplegia occurred in eight cases out of the sixty; once the group of symptoms

pointed to a hemiplegia spinalis. The prognosis of brain syphilis is, according to Naunyn, always doubtful. The number of cases which entirely recover is very small. In any case, however, the prognosis is more favorable than when the same symptoms are due to any other cause. Naunyn uses mercurial inunctions, and only employs iodide of potassium occasionally.

DIURETIC EFFECT OF COMPRESSED AIR WHEN USED IN PURULENT PLEURITIC EXUDATIONS.—Kelemen (*Pester Chir. Med. Presse*, 1879; from *Berl. Klin. Wochenschr.*, 1879, p. 404), having occasion to use compressed air in a case of pleuritic exudation, observed an increase in the quantity of the patient's urine while under this treatment. The patient had been passing 1291 cm. daily, but this amount gradually increased to about 2600 cm. This explains Waldenburg's experience with this treatment, who observed increase of cardiac action, increase of blood in the aortic system, emptying of the smaller circulatory system, with greater quantity of blood flowing in the capillaries of the larger circle. The diuretic influence of compressed air, when used in heart disease, has already received some attention at the hands of Rosenstein.

HEART-SOUNDS AUDIBLE AT A DISTANCE.—Ebstein (*Berl. Klin. Wochenschr.*; from *Deutsches Archiv für Klin. Med.*, Bd. xxi. Heft 2) has collected a number of cases in which the sounds of the heart in cardiac and aortic disease could be heard at a distance of 0.5 to 1.0 metre (20 to 40 inches), or more. Both pericardial as well as systolic and diastolic endocardial murmurs are sometimes heard considerable distances. Stenosis of the aortic orifice, particularly in cases of high grade where there is calcareous degeneration of the valves, is most apt to give rise to loud sounds. No cases of bicuspid valvular disease accompanied by a loud murmur are on record. In one case of severe aortic stenosis, combined with insufficiency and mitral stenosis, the murmur was heard seven feet off. Occasionally the sounds of the heart can be heard by the patient himself, and this phenomenon may be transitory.

INFLUENCE OF SYPHILIS IN INJURIES AND WOUNDS.—Verneuil (*Cbl. f. Chirurgie*, 1879, p. 575; from *Rev. Mensuel*) gives some new facts bearing upon his favorite subject. They are as follows: 1. Amputation of thigh in a subject of syphilis 27 years of age.

Three days later, papular syphilitic. On the 19th day, stubborn specific sore in the wound. 2. Man 30 years of age; latent syphilis; simple fracture of tibia. No consolidation. Dieffenbach's operation followed by profuse suppuration; still no consolidation. Two months later, syphilitic with iritis. Cure under antisyphilitic treatment; consolidation of the fracture in a little less than a month. 3. Stricture of the rectum in a syphilitic individual 40 years of age; vertical division; development of a rectal syphilitic, together with a pustular syphilitic. 4. Hydatid cyst of the femoral muscles in a girl of 20. Incision; drainage; exfoliation of the cyst. Two years later, development of a syphilitic in the scar. Cure with mercury and iodine. 5 and 6. Two other cases of syphilis following wounds. 7. Woman 41 years of age; old, supposed non-specific onychia; cauterized. Rapid development of subcutaneous gummata; aphasia; hemiplegia; death. Verneuil considers the slight trauma in this case the cause of death. Dürerhoff and Volkmann deny the connection between syphilis and trauma, and were it not for Verneuil's high reputation his cases would carry still less weight than they do with surgeons. He, however, is a firm believer in his theory, and even believes in a connection between rheumatism and trauma.

TUBERCULOSIS OF THE IRIS.—At a recent meeting of the Société de Chirurgie (*Gaz. Hebdom. des Sci. Méd. de Montpellier*, 1879, v. ii. p. 44) Dr. Parinaud presented notes of the case of a child 12 years of age, born of tuberculous parents, who had complained for five months of feeble sight. Examination of the globe which was free from pain showed a peculiar condition of the iris, which displayed a number of tumors upon its anterior aspect, some near the pupillary border, others at the periphery. They were yellowish in color, one of them showing small vessels upon its surface, together with numerous small projections; and they were four or five times the size of a pin's head, projecting into the anterior chamber. Vision was much interfered with; the *globus oculi* was hard and deeply congested. Ophthalmoscopic examination failed to show any involvement of the deeper structures of the eye, although this alone would account for the feebleness of vision. In the discussion which followed the reading of this paper various opinions were expressed

with regard to the necessity of removal of the eyeball. Dr. Auger favored the removal of the eye as a useless and dangerous organ which might become a focus of infection for the entire system, like organs which are the seat of malignant tumors. Dr. Verneuil protested against such opinions as German, and blamed the trans-Rhenish surgeons for assimilating tubercle with malignant tumors. Messrs. Després and Trélat agreed with Verneuil, while Giraud-Teulon was inclined to connect tubercle with malignant tumors. He counselled enucleation. M. Tillaux also suggested operative interference, only delaying until the condition of the eye became aggravated, or until sympathetic trouble appeared.

INNERVATION OF THE HEART.—M. François Frank (*Gazette Hebdomadaire de Méd. et de Chirurgie*) states in a *résumé* of our recent knowledge on this subject that the heart enjoys an activity independent of the central nervous apparatus, its automatic action arising from the ganglionic apparatus which it contains. These ganglia are divided into auto-motors which incite the diastolic movement, and moderators which command the systole. In the normal condition, the heart is also under the influence of the central nervous apparatus,—an influence transmitted by two orders of nerves, functionally distinct: accelerators belonging to the sympathetic, moderators represented by the pneumogastric. As to their termination in the heart, these nerves are intimately connected with the parietal ganglia. M. Frank gives a detailed *résumé* of the origin and action of these nerves which is highly interesting, but of which our want of space prevents the insertion.

HÆMATURIA DUE TO QUININE.—According to Dr. Georges Karamitsas, of Athens (*Bull. Gén. de Thérap.*, v. ii., 1879, p. 149), quinine may provoke hæmospherinuria, often accompanied by an access of fever quite independent of hæmaturic malaria. This condition may be brought about by small doses of the drug, which is not only not indicated in those having this predisposition, but is harmful and may even be dangerous. When hæmaturia is observed to follow the ingestion of quinine, this should on no account be administered.

DIAPHRAGMATIC HERNIA.—Bardenheuer (*Cbl. f. Med.*, 1879, p. 526; from *Berliner Klin. Wochensch.*) gives the case of a man 32 years of age, who was shot through the

left breast. Hæmoptysis followed, but the wound healed within four weeks; subsequently cramps in the pelvis, with digestive disturbance, occurred from time to time. Seven years later ileus suddenly appeared, for which laparotomy was performed; the strangulated portion of the intestine not being found, an artificial anus was made in the ascending colon. Two days later, the patient died of septic peritonitis. Examination showed old bullet-wounds cicatrized about the edges in the diaphragm, in which a portion of the omentum had been squeezed. Together with this, there was a stricture of the left flexure of the colon.

SUPPOSITORIES OF TARTAR EMETIC IN CEREBRAL TROUBLES.—Dauvergne (*père*) writes to the *Bulletin Général de Thérapie* (1879, p. 176) recommending a suppository composed of 1.6 grains of tartate of antimony, introduced night and morning into the rectum recently emptied by means of an enema. This suppository causes a powerful divulsion into the mesenteric circulatory system, and thus relieves cerebral congestion to a marked degree. Of course this treatment need not exclude the usual revulsives,—leeches to the nape of the neck, ice to the head, calomel in repeated doses.

YPECAC AS A HÆMOSTATIC.—Pécholier (*Jour. des Sci. Méd.*, 1879, p. 513; from *Bull. Gén. de Thérap.*) speaks of the singular property possessed by ipecac of chasing, so to speak, the blood from the lungs. That this is not due to the vomitive action is probable from the fact that tartar emetic does not seem to act in the same manner. The pulmonary anaæmia is due, according to Pécholier, to a special action of the ipecac quite distinct from its nauseating or vomitive properties. The dose given (3*i*) is not, strictly speaking, a vomitive dose, and even when vomiting is produced, a certain amount of the drug enters the general circulation. Pécholier's favorite prescription is as follows:

B Ipecacuanha contus., 3*iss*;
Aquaæ bulliente, f3*iv*.
Make an infusion; filter; add syrapi acaiae f3*i*. Give a tablespoonful every hour or two.

The first dose may cause vomiting; but this soon ceases, and, indeed, may be prevented by the addition of a few drops of laudanum. The absorption of the emetic being thus rendered easier, pulmonary anaæmia is rapidly and surely produced.

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA, OCTOBER 25, 1879.

EDITORIAL.

MEDICAL EDUCATION.

FOR some years this journal has consistently and urgently pleaded the necessity of reform in the American methods of medical education. For a time the case seemed hopeless, but by and by, under the pressure of a public opinion which grew almost as rapidly as Jonah's gourd, the changes in the curricula of the medical schools began to betray an uneasiness on the part of the most stolid faculties. Then the Universities of Pennsylvania and of Michigan essayed the experiment that had already been tried at Harvard. With the result at the University of Michigan, so far as this year is concerned, we are not familiar, but at the University of Pennsylvania the pecuniary success of the new plan is assured. A class of nearly four hundred students, yielding a revenue almost one-third larger than that received by the school previous to its change of plan, marks the present session. As more than one-third of the whole present class is composed of first-year men, and as the number of these medical beginners is about ten per cent. greater than last year, the success of the future, as well as of the present, may be considered as determined.

Of all the medical schools in the country, those which have done the most injury to the profession and to the people of these United States are to be found in New York City. Here in Philadelphia we have wrought evil sufficiently, but New York has in this, as in so many other things, exceeded us. Until very recently there was no apparent prospect of a change in the existent status of the medical colleges

of our rival city. But a few days since we were delighted by a circular from Bellevue Medical College, announcing that after the present year a preliminary examination and attendance upon three graded courses of lectures, with annual examinations, would be required of candidates for its diploma. We congratulate the trustees and the faculty of the college most heartily upon this sudden transformation. We hail it not merely as a good deed done, but as an indication of the continuous growth of public opinion, and as an omen of future progress.

It is certainly becoming more and more apparent that the school which desires to be considered *even respectable* must adopt the new methods. How the College of Physicians of New York — the old, the aristocratic — can endure to see itself looked down upon by its younger colleague, and to feel that the profession universally recognizes its shame, it is hard for us to understand. Certainly, if the faculty be not influenced by these things, the alumni must be, and the agitation among them must eventually be felt in high quarters. We opine that if Bellevue be true to itself, its promises, and the great step it has taken, not only will its own direct power and influence increase rapidly, but it will force the College of Physicians and Surgeons to follow its lead.

Public opinion is already reaching the point that the reputation of medical men who are connected with schools of the old style is beginning to be injured (at least, in the profession) instead of being increased by the connection. In time this loss of prestige will become so great that in very self-defence men of eminence will shrink from belonging to an inferior school, even if a large pecuniary reward is to be reaped by the dishonor.

If there be one man more than another that the profession of this country delights to honor, it is the venerable surgeon of this city. The distinction of having led

into the paths of reform and progress the great medical school whose success has depended more upon him than upon any other man, would be a crown most befitting to a life so replete with well-earned honors and rewards. Will he leave his alma mater with the feeling, which must be in every breast, though unacknowledged, that it is sinking down in the grade of educational institutions? or, will he put it, where it ought to be, in the foremost rank of the medical schools of the country?

THE misrepresentations that have, unwittingly it may be, been made in regard to the changes in the system of medical instruction at the University of Pennsylvania have been so confidently and frequently repeated that it seems necessary to tell the truth.

The latest exposition of these false statements is contained in the speech made by Professor Hamilton before the American Academy of Medicine. An institution has no moral personal existence; its policy is, of course, at any given time, the reflection of the moral or personal character of those who are at that time in charge of the institution. Hence it is absurd to judge the action of the present trustees and faculty by any reference to the actions of past boards or faculty, as Prof. Hamilton has done.

The changes in the system of medical teaching were not simply made, as is asserted, when nothing could be lost, but were carried out at a great pecuniary risk, and have resulted in loss to individual professors.

In order that the loss should not fall solely upon the faculty, a sum of money was conditionally subscribed, nearly all of it by the wealthier members of the Board of Trustees and faculty. The guarantee given was in no case for a salary equal to what the professors had received the year before the change, and which they had every reason to believe would be main-

tained under the old system. In the case of the younger members of the faculty, the reduction was very severe. The unexpected success of the school under the new régime prevented the shrinkage from being as great as was anticipated, but the aggregate loss to the individual professors has reached a very respectable sum. The change was made as a matter of conscience, although effort was put forth not to allow the whole loss to fall on a few men.

In view of the increased receipts of the school, it may be wondered why the salaries are lessened; but it must not be forgotten that the teaching corps has been increased in numbers in the proportion of seven to eleven, whilst the receipts of the school, including all moneys received from endowment, have not until this year, even with the unexpected classes, increased more than twenty per cent.

THERE are some cases in which the suffering from *hay fever* is so excessive that the patient will be willing to try the remedy suggested by Dr. C. M. Sebastian and found by him successful in one case, namely, the constant wearing of a thick veil. Probably well-fitting respirators so constructed as to strain the air thoroughly will be found both useful and comfortable.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY EVENING, JUNE 12, 1879.
THE PRESIDENT, DR. H. LENOX HODGE, in
the chair.

Tubercular ulceration of ileum. Presented
by Dr. FREDERICK P. HENRY.

D. S., æt. 53, male, white, was admitted to the Episcopal Hospital on March 3, 1879, and died about June 1. When I first saw him, on April 1, he was greatly emaciated and extremely feeble, with a pulse that was pretty uniformly at about 100, slight and infrequent cough, and, although there was very marked dulness on percussion over the upper half of left thorax, inspiration was so feeble, owing to extreme atrophy of the muscles concerned in the act, that râles were

never detected. There was diarrhoea, ranging from five to ten watery stools daily, in which blood was never observed. The man had been addicted to the use of opium in what may be called a moderate degree, never having exceeded 3iss of laudanum per diem. The case gradually proceeded to a fatal termination. The treatment consisted in astrigents, opiates, cod-liver oil in the form of pancreatic emulsion, and, later, by inunction and prophylactics against bed-sores.

At the autopsy the lungs were found far advanced in phthisis, especially the left; the surfaces of both were very uneven and puckered, and some small cavities were found in the apices of both, the largest—about the size of a walnut—in the left. The pleura on the left side were universally firmly adherent, but on the right there were parts free from adhesion, although here also the adhesions were very extensive. All the tissues examined were very dry, and the large veins contained very little blood. The great omentum was completely destitute of fat, and resembled a simple serous membrane; its vessels, as well as those of the mesentery, were plainly visible, and, on holding them up to the light, a beautiful picture of the vascular distribution was obtained. The mesenteric glands were all enlarged almost uniformly, the largest being about the size of a Lima bean. The mucous membrane of the ileum was the seat of a number of tubercular ulcerations, scattered along it at intervals of from one to three feet. They were of typical appearance, their long axis being at right angles to that of the intestine, while the peritoneum opposite their base was studded with miliary tubercles. The kidneys were moderately granular.

Portion of colon from a case of chronic intestinal catarrh. Presented by Dr. LOUIS STARR.

This piece of intestine, comprising the ascending colon, with the beginning of the transverse colon, was obtained from a man who was formerly a patient in the medical ward of the Episcopal Hospital. He was 58 years of age, an engineer, and had enjoyed fair health until eight months before admission. Subsequently he had suffered from diarrhoea, the evacuations varying much in frequency, often numbering, according to his own statement, twenty or thirty in twenty-four hours, but sometimes only three or four, while occasionally there was no movement of the bowels at all for a day or two. After the onset of the diarrhoea, prostration and loss of flesh were rapid and continuous. One month before admission his feet and legs became oedematous.

When first seen he was very weak and anæmic; there was general anasarca, and there were frequent (twenty in twenty-four hours) copious evacuations of the bowels, the stools consisting of colorless liquid contain-

ing masses of mucus and partly-digested food. The urine was diminished in quantity, but was otherwise unaltered. No lesion of the heart or lungs could be detected.

Death occurred two days after entering the ward. At the *inspection*, all the viscera were found to be normal except the large intestine. This seemed to be reduced in calibre, and, when laid open, the whole of the mucous membrane, from the ileo-colic valve to the lower part of the rectum, was found to be studded with minute ulcers about as large as a pin's head, the intervening portions being ash-colored, thickened, and covered with villous projections.

I am indebted to the resident physician, Dr. D. J. Milton Miller, for the notes of this case.

Hemorrhagic infarctions of the mucous membrane of small intestine. Presented by Dr. FREDERICK P. HENRY.

In addition to the intestinal specimen, there are before the Society a small ovarian cyst, a hemorrhagic infarction of the liver, and a pair of cystic kidneys, all taken from the same subject. I have given prominence to the intestinal lesion because it is rarer than the others, and because I have just presented a specimen of intestinal disease.

The patient was a white female, æt. 24, who was admitted to the Episcopal Hospital on May 24. I saw her once at her house before her admission, and made the diagnosis of peritonitis. She went to the hospital the next day (Saturday), arriving after I had made my visit, and died on Monday morning. The clinical history, therefore, is a short one, and is condensed from notes made by Dr. Bickford, the resident physician.

The patient says she has always been healthy until the present time. Menstruation has been regular until the last period, which was delayed two weeks, the discharge appearing the day before admission. The attack began on Wednesday, after three or four days of malaise, headache, pain in back and stomach. On Wednesday she was obliged to stop working at the laundry where she was employed. On her way home she had a chill, followed by high fever, which has continued up to the present time. There does not appear to have been the usual severe pain of acute peritonitis. At the beginning of the attack the bowels were quite loose. Tongue dry and bright red. There was tenderness in right iliac region, and in a lesser degree in the left; aching pains over the whole body, especially on moving; a tympanitic abdomen, and some nausea and vomiting.

On the 25th the menstrual flow continued, and the abdominal pain was more severe; there was also more vomiting and a greater degree of nausea. The pulse in the evening was 140, and the temperature 103° F. Death took place, somewhat suddenly, on the 26th,

at 6 A.M., immediately after the patient had sat up in bed to take some nourishment.

Autopsy.—The peritoneal cavity contained about 10 of turbid serum. The intestinal coils, where free from lymph, showed an intense degree of congestion. Unattached masses of lymph were found in different parts of the abdomen, and were so consistent as to be readily lifted and removed by the forceps. The amount of lymph was greatest in the hypogastric region, and the external surface of the uterus was greatly congested, although free from lymph. No pus was to be seen. There was an ovarian cyst, the size of a large orange, occupying the site of the right ovary, which contained a limpid, straw-colored liquid. The surface of the liver was the seat of a number of minute cysts, and on the superior surface of the left lobe there was a hemorrhagic infarction, whose circular base, nearly the size of a quarter-dollar, corresponded to the liver-surface, below which it was slightly depressed. On section, it was found to be in shape like a triangle with rounded apex. The kidneys presented an extreme degree of cystic degeneration, the left containing one cyst the size of a walnut and numerous others of smaller size, while the right was of an almost sieve-like appearance on section, owing to the number of cysts divided. The intestinal mucous membrane, at various points, was the seat of hemorrhagic extravasations of circular form, the largest the size of a small pea; they were easily ruptured, and gave exit to fluid blood. The uterine mucous membrane, especially the cervical portion, was intensely congested. There was double pleurisy, with a small amount of turbid effusion at the bottom of both pleural sacs, and soft lymph on the pleural membrane.

In this case there are two distinct processes of disease,—a chronic and an acute,—the former being the predisposing cause of the latter. The causal relation between extensive inflammation of serous membranes and chronic kidney-disease is a well-established fact in pathology. The nature of the woman's occupation is also to be considered, both in the etiology of the peritonitis and in that of the menstrual suppression which was probably the exciting cause of the former. Hemorrhagic infarction is less commonly observed in the intestine than in the stomach, where it is recognized, by some authorities, as the first stage in the development of gastric ulcer.

THURSDAY EVENING, JUNE 26, 1879.
THE PRESIDENT, DR. H. LENOX HODGE, in
the chair.

Concretion from the vermiform appendix.
Presented by Dr. FREDERICK P. HENRY.
C. F., a machinist, of temperate habits, was admitted to the hospital of the Protestant Episcopal Church on June 6, 1879, having been ill one week. On admission, he

complained of pain over the whole abdomen, which was, however, particularly severe over the external portion of the right hypochondriac region. The tongue was slightly furred, and there was occasional bilious vomiting. Pulse 88, and very tense; temperature 101° F. The urine was acid, specific gravity 102.7, and contained a trace of albumen. A microscopic examination which I made on the 16th revealed the presence of a few faintly granular casts. No cause for the attack was known, and the onset was gradual. After two or three days of malaise, poor appetite, and sensation of fatigue, pain, described by the patient as resembling that of a bruise, was felt in the abdomen, especially in the right side. This pain gradually increased in severity until it became extreme. There was a history of previous attacks of intermittent fever,—the last in 1873,—and of articular rheumatism in 1876.

The decubitus was dorsal, with the right thigh and leg strongly flexed.

Without entering into the details of treatment (which were, however, of unusual interest), I may say that, the diagnosis of acute peritonitis being manifest, the main reliance was placed upon morphia. As an example of the manner in which the drug was used, I will mention that by the 11th, five days after admission, the patient had taken, of liquor morphiae sulphatis, one hundred and fifty-eight drachms, with alleviation of all the symptoms, and without the production of narcotism. This was at a period when the drug was most sparingly used. At a later stage it was given on several successive days, in doses of gr. ss, every hour for the greater portion of the day, and, in spite of this, the respirations were never less than eighteen per minute, and, although the pupils were very greatly contracted, the patient could always be readily roused by speaking to or touching him. The bowels were spontaneously moved on several occasions. There was a pulse-range from 88 on the morning of the 6th to 160 on the evening of the 16th, and a temperature-range from 98.5° F. on the morning of the 9th to 103.5° F. on the evening of the 7th.

The man died on June 20, fourteen days after admission.

Autopsy.—On opening the abdomen, a quantity of pus, estimated at about one pint, poured out of the incision. The intestinal coils were so firmly glued together and to the abdominal parietes that their removal was a work of great difficulty. The cæcum was sought for at once, but not readily found or removed, owing to its being covered by adherent coils of small intestine. The vermiform appendix curled round the anterior portion of the cæcum, to which it was attached for the greater portion of its length, and near its extremity was found a perforation, immediately above which a hard substance was felt, filling its calibre; a slight pressure caused

this to escape from the opening, and its exit was followed by pus. The foreign body is in shape precisely like an apple-seed, although somewhat larger, and its roughened surface is formed of a dark, grayish-brown, calcareous-looking substance. The signs of peritonitis were not more marked in the neighborhood of the cæcum than elsewhere, nor was there any apparent attempt at the formation of a peri-cæcal abscess. Pain was never particularly referred to the right inguinal region, but always, as has been said before, to the external portion of the right hypochondriac region, and, corresponding with this, there is to be seen, on the superior surface of the right lobe of the liver, a circular patch of lymph, about three and a half inches in diameter, which was firmly adherent to the inner surface of the ribs. The surface of the liver at this point is slightly depressed, but, on section, nothing abnormal, beyond a great degree of congestion, was found. The kidneys were very unequal in size, the right being below the normal in this respect, the left above it; but the relative proportions between cortical and medullary substance in the two organs, and their color and consistency, were normal. The spleen was covered with a thick layer of lymph, and was shrunken. Two bodies, which correspond in situation with the appendices epiploicæ, being attached to the large intestine by a short mesentery, present an unusual appearance. Their surface is of a bluish-purple color, and on section their tissue is of a brownish-red hue, resembling that of the spleen. They are about the size of an ordinary marble. One of these, attached to the splenic flexure of the colon, is before the Society. No other than the abdominal organs were examined.

Report of the Committee on Morbid Growths. — "A microscopic examination of the body attached to the splenic flexure of the colon shows it to have all the histological elements, and a similar arrangement of the same, as found in the normal spleen. The nodule is therefore one of those not unusual abnormalities, a supernumerary spleen.

"September 11, 1879."

Perforation of the vermiform appendix. Presented by Dr. J. T. ESKRIDGE.

I am indebted to Dr. Campbell for portions of the clinical history of the following case: B. F., male, æt. 19, had always been healthy, though of constive habit, until January, 1879, when he complained of pain in his right side, which was severe enough to prevent his lying straight in bed at night; but of this he was soon relieved, and was again considered perfectly well till the early part of April, when he had a second attack of pain in the same locality. During the latter part of April, while attending a circus, he was thoroughly wet by a drenching rain, and ate largely of peanuts. About May 1 he was heard crying, while at

stool, on account of a sharp pain shooting upwards and to the right side of the belly. On the 2d and 3d he complained of soreness in the right iliac region, and was given by a druggist two doses of purgative medicine in one day, and on the 4th the cramps were worse, and he was compelled to lie in bed, but was given, by the same druggist, a table-spoonful of purgative medicine every half-hour till he had taken a large bottleful, to no effect except to aggravate the pain. May 5, he was seen by a physician, who had his bowels opened by an enema. May 6 and 7, he was better, went down-stairs and sat up, but there was considerable soreness in the right iliac region. He had a chill during the afternoon of May 8, and Dr. Campbell saw him for the first time about 8 P.M. He complained of great pain near the umbilicus. The prostration was great, countenance pinched, pulse quick and wiry, and temperature 99° F. Counter-irritation was applied to the abdomen, followed by warm and moist applications, and he was given calomel, extract of opium, quinia, and rhubarb. Pain relieved by morphia. May 9, at 9 A.M., pulse 110, temperature 100° F., and respirations 40; nausea, vomiting, and great pain; patient sinking. About noon of the same day, I saw the patient, in consultation with Dr. Campbell, and found him lying on the right side, with legs drawn up. There was moderate tenderness over the abdomen, but most marked in the right iliac region, and the right rectus muscle of the abdomen was quite tense; pulse 120, respirations 50, temperature 100° F.; incessant nausea and vomiting, and a distressing thirst. The appendix was agreed upon as the seat of trouble, and perforation was supposed to have taken place the day before. At my suggestion, an enema composed of milk and brandy, with a little laudanum, was given. At 11 P.M., felt better, wanted beer, pain gone, but thirst continued, and he was now vomiting stercoreous matter; pulse 160, respirations 60, temperature 99° F.; patient sinking. May 10, chill at 5 A.M., and died one hour later. Vomited faecal matter to the last. No swelling of the stomach.

Autopsy, thirty hours after death. — The abdominal cavity only was examined. No accumulation of gas. Peritoneum highly congested, and in the right iliac region several adhesions had formed. Pus was abundant in the neighborhood of the appendix, and small deposits of the same were found in the umbilical, hypogastric, and left iliac regions. The cæcum, lower portion of the ileum, and beginning of the colon were highly congested, and the appendix, the seat of the original trouble, had undergone suppuration, and was perforated by two holes. The supposed offending substance which was thought to have given rise to the trouble in the appendix was diligently searched for in every

part of the abdominal cavity, but it was not found.

The history of this case is the history of most cases of suppuration of the appendix. There may be, as there was in this case, a history of one or more previous attacks of pain in the right iliac region, but the most characteristic and interesting part of the history of suppuration of the appendix is the attack of cramps or pains in the right iliac region, lasting two or three days, according to circumstances, followed by a remission or lull, and this in turn, in a day or two, is followed by a chill, great prostration, and all the evidences of general peritonitis and impending death.

If we bear in mind the usual cause of this trouble, we may in many cases, if consulted early, be able to save, or at least to prolong greatly, our patients' lives. Most foreign substances found to have given rise to perforation of the appendix have been shown to be concretions of faecal matter. I am not sure that a well-authenticated case is on record where a seed or stone of any kind has found its way into the appendix and caused suppuration and perforation. A number of such have been reported, but none of these were examined microscopically. About one year ago I had occasion to look up this matter, and I was unable to find a satisfactory example. That such a thing could never occur there is no reason for thinking. There are a number of cases reported where foreign bodies, such as pins, tacks, etc., have been found in the appendix, some giving rise to perforation, and others causing no appreciable difficulty.

In the London *Lancet* for March, 1879, Dr. Whiphian read notes of a case of perforation of the appendix cæci and of the cæcum, followed by pyæmia, empyema, and abdominal abscess. At the autopsy an abscess was found in the right iliac region, and free in the cavity lay a pin, which had made its way through the cæcum and its appendix into the abdominal cavity. In the discussion which followed, Dr. Southey related a case in which perforation of the appendix was caused by a tin tack, and Mr. Hulke a case of ulceration of the cæcum caused by impaction of damson stones, but he does not state whether these stones were examined microscopically; at any rate, nothing is said of their having found their way into the appendix. On the other hand, showing the toleration of the appendix for foreign substances, in the first number of the *New York Medical Record* for 1879 a case is reported of accidental death, and at the autopsy a pin was found in the appendix, and, so far as could be ascertained, the man had never complained of pain in that region; and in one of the London medical societies, several years ago (mentioned at one of this Society's meetings, more than a year ago, by Dr. John Ashurst, Jr.), a case was reported

in which, at the autopsy, the head of a pin was found in the appendix and its point in the bladder, around which a good-sized urinary concretion had formed.

Since most of these cases of perforation of the appendix are caused by concretions of faecal matter, and since these concretions may lie in the appendix for an indefinite time without giving rise to trouble, as is often shown by their presence at autopsies, and in the dissecting-rooms, where we have nothing to lead us to suspect trouble in the appendix, we must look beyond their mere presence for an exciting cause. This I think we may attribute to the muscular action of the bowel and appendix. A faecal concretion may have lain in the appendix for years, giving rise to no irritation till the bowels are unduly excited by some foreign substance or irritated by cold, when the peristaltic-like movements may be transmitted from the bowel to the appendix, and what before was harmless now becomes an irritant as it is caught between its walls.

The treatment of these cases deserves the greatest care on the part of the most intelligent physician. In most of the cases of perforation of the appendix that I have seen, death has been caused by early, free, and heedless purgation. I have no doubt that the present case might have been saved had he fallen into the hands of an intelligent and careful physician instead of the ignorant and unscrupulous apothecary, who added greatly to his sufferings and danger by the liberal use of purgatives.

I have come to regard purgatives as powerful agents, either for weal or for woe.

Cystic kidneys. Presented by Dr. R. W. Deaver for Dr. W. W. Lovejoy.

G. F. B., æt. 42, artist; irregular habits; had been ill for six months, though he had worked at his easel two weeks before his death. In the early part of his illness had severe dyspeptic symptoms.

Had been under homœopathic care until forty-eight hours previous to his death, when I first saw him. He was propped in a chair, face injected, breathing rapidly, and in a state of partial stupor. His feet were swollen and dropsical, the œdema reaching above the knees; skin was hot and pulse rapid; had a slight cough, and had complained of pain in left side. The next day he was flighty and restless; pulse and breathing jerky. His delirium was of a happy character, though, other than one-twelfth grain of morphia, no drug had been taken. He died the following night.

As far as could be learned, he had never had any retention or suppression of urine, and a specimen passed two hours before death was free from albumen. His homœopathic adviser had found it necessary to tap both his abdomen and legs several times, and, the day before I saw him, had given him one-quarter grain of morphia.

Owing to his hopeless condition when first seen, no physical examination of his chest was made.

Post-mortem.—On opening the thorax, the lower portion of the right lung was consolidated and its surface covered with recent lymph; the right pleural cavity contained one and a half pints of effused liquid. The left lung normal; heart dilated, but no valvular disease; the liver normal in size, with very little irregularity upon its surface,—possibly a cirrhotic change, though it was very slight. The abdominal cavity was filled with liquid; the kidneys were enlarged, studded with cysts,—their combined weight three and a half pounds.

Scirrhoma of breast and axillary glands.
Presented by Dr. JAMES E. GARRETSON.

The specimen shown consists of a left mammary gland and a chain of lymphatic vessels and glands taken from the person of a lady aged about 50.

The mamma, enlarged to thrice its ordinary size, very hard, showing, on section, the stroma like a turnip, was amputated, six weeks back, by Dr. Markley, of Hatboro', in this State. At the time of operation, the disease had not extended its boundaries beyond the body removed.

Sunday, June 15, being in the neighborhood for the purpose of doing an operation for a patient under Dr. Markley's medical care, my attention was called to the case under description.

As seen at this visit, the wound previously made was found fairly healed. At the seat, however, where the uniting process had been best completed, there was found an indurated mass about the size of a hen's egg. No involved neighboring glands exposed their presence to the touch.

Sunday, June 22, by engagement, I met Dr. Markley at the house of the patient, for the purpose of doing a second operation. Examination was made for axillary involvement, but nothing exposed itself.

Commencing the operation by a cut that should lay bare the pectoral muscle, and dissecting the mass from that muscle, it was found connected with a second involvement lying just below the free edge. This, in turn, was connected with another body, and so on one after another, until the large number here shown were dissected from the region of the armpit and neighboring parts. The extent of involvement I offer as a rare one in my own experience. I have never before removed, nor have happened to see removed, so many glands from this region. The number of those here shown is twenty-two; at least half a dozen were not saved.

A postal received this afternoon at three o'clock, from Dr. Markley, reads as follows:

"Have seen Mrs. G. this A.M. She rested well last night. Pulse reduced to 112, with all indications favorable."

REVIEWS AND BOOK NOTICES.

THE HEART AND ITS DISEASES, WITH THEIR TREATMENT; INCLUDING THE GOUTY HEART. By J. MILNER FOTHERGILL, M.D., Member of the Royal College of Physicians of London; Associate Fellow of the College of Physicians of Philadelphia, etc. Second Edition (entirely re-written), with Illustrations. Philadelphia, Lindsay & Blakiston, 1879. 8vo, pp. 476.

In scarcely any department has medical literature grown so rapidly of late years as in that of the heart and its diseases. Indeed, the accumulation of volumes upon our shelves would fill us with dismay, were it not that each new acquisition bears witness that it is not merely a multiplication of writings with which we have to do, but a development and advancement of our common knowledge of the subject such as can scarcely be found elsewhere in the entire domain of medicine.

Now, as always, it is the English-speaking workers in this field that are most active. The Three Kingdoms have been vying with one another. Hayden's encyclopædic work was quickly followed by that of George Balfour, of Edinburgh, in which much scattered knowledge of the natural history of heart diseases was so well brought together and so strikingly presented by a master-hand that new light was thrown upon the whole subject, a light marking an epoch in the clinical study of cardiac affections and their management. Now Fothergill, of London, adds a contribution to the subject, of which it is high praise to say that the author has fully succeeded in his aim to portray each form of disease of the heart, not as presenting merely a collection of signs and symptoms, but as possessing a clinical history. His "belief that such plan will interest practitioner and student alike in the genesis and progress of diseases of the heart" is well founded, and that it "will furnish indications for treatment, preventive and other, which are not supplied by the plan of regarding diseases of the heart too exclusively from the point of view of the relations of the signs and symptoms found in life to the revelations of the dead-house," is realized in almost every page.

We speak of it as a new book. So it is, in spite of its being dubbed a second edition. It is so "entirely re-written" that its older brother would not know it. The first two chapters are devoted to the anatomy and physiology of the heart. The evolution of the heart as illustrated by its comparative anatomy, some pages contributed by Mr. Alban Doran, will interest all students; while the description of the anatomy of the cardiac nerve-supply, from the pen of Mr. H. A. Reeves, serves as the key to much that follows, and will often be gratefully referred to by every careful reader.

Among the practical points Dr. Fothergill gives the following: "In some respects our knowledge of heart diseases has retrograded. Much that lies outside mere physical signs has been forgotten. The works of Hope and Latham, full of philosophical considerations of the greatest value, have given place to works more devoted to the consideration of diagnosis and the requirements of the examination-table rather than the needs of the bedside." It is our author's aim to blend the old bedside skill in healing with the newer diagnostic acumen, and from the two to deduce a hopeful therapeusis founded upon a sound and comprehensive pathology. How practical this aim is, no reader need be told who has earnestly striven to utilize a scientific knowledge of these maladies in their treatment.

Those who have read Dr. Fothergill's scattered writings will find in the following excerpts a familiar ring; to others they will serve to make known the character of his work and the suggestiveness of his style:

"The aortic second sound is modified by a thickened edge of the aortic valves, and such muffling is not rarely heard before the valvulitis has led to the production of a murmur."

"The diagnosis in diseases of the heart is not the end but the beginning of the examination, and its accuracy is of value, not as a clever feat of intellectual legerdemain, but only in so far as it enables the physician to comprehend the disease and strengthens his hands as to the appropriate treatment."

"The day of the prominence given to the presystolic murmur will soon be over."

In endocarditis "blisters over the heart are troublesome and their utility most questionable."

"Albuminuria is not a prominent indication of the gouty kidney, and is seldom present, and then very slight in amount, till the last stage of heart failure is reached."

Thirteen chapters are devoted to the maladies of the heart and their pathology, of which the author thinks, with Latham, the treatment is, in fact, a part; one to the separate consideration of the principles of treatment in organic disease; one to cardiac malformations; and, finally, one to the elements of prognosis in heart disease.

The section on the sphygmograph is from the hand of Dr. Balthazar Foster.

In the valuable chapter on prognosis the conclusions reached by Dr. Angus MacDonald in his recent work on "Heart Disease during Pregnancy" are given *in extenso*.

Well-made cuts complement the text where needed, and two plates, reproduced from "Basham on Dropsy," illustrate atheroma and fatty degeneration of the arterial walls and their associated degenerative changes.

The easy, fluent, readable style of the author is known to the readers of the *Times*. We commend heartily to them this his latest and

most important work. To many an earnest student it will prove a light in darkness; to many a practitioner cast down with a sense of his powerlessness to cope with the rout and demoralization of nature's forces, a present help in time of trouble.

J. C. W.

LES TUMEURS ADÉNOÏDES DU PHARYNX NASAL : LEUR INFLUENCE SUR L'AUDITION, LA RESPIRATION ET LA PHONATION. LEUR TRAITEMENT. Par le Dr. B. LCEWENBERG. Paris, 1879.

This pamphlet of seventy-five pages, as its title announces, is a treatise on so-called adenoid tumors situated in the naso-pharynx,—the space above the velum palati, as the author defines this term,—and the influence which such growths exert upon audition, respiration, and phonation, together with the treatment to be adopted for their removal.

The author divides these tumors into two classes, viz., sessile and pedunculated, but admits that they may assume the shape of granulations. He then enters upon the symptomatology, and considers, in a very able manner, the great variety of symptoms to which such neoplasms may give rise, and lays particular stress upon the effect produced upon the general health of the patient and upon the physical development in children.

The differential diagnosis between adenoid tumors of the naso-pharynx and chronic coryza, hypertrophy of the tonsils, nasal polypi, post-nasal polypi, and other conditions, is at length discussed.

The latter part of the treatise is devoted to the consideration of treatment, and is divided into general tonic and local treatment. The latter again is subdivided into cauterization with solid nitrate of silver, and ablation with a peculiar pair of forceps invented by the author and pictured in this treatise.

The pamphlet is well written, and contains a great deal that is new and of interest to the profession in general, for adenoid tumors, or at least granulations, in the naso-pharynx are by no means as uncommon as might be supposed, and are not oftener found because they are not particularly looked for with the rhinoscope, especially as the symptoms very closely resemble those of the ordinary post-nasal catarrh.

VOMITING IN PREGNANCY — COPEMAN'S METHOD.—Dr. J. T. Baldwin, Professor of Anatomy in Columbus Medical College, reports three cases of the successful application of the above method. It consists in thoroughly dilating the external os and cervical canal with the finger. In one case almost every other measure had been previously tried, and abortion was being seriously considered. Upon dilating the cervix, however, the vomiting ceased at once.—*Ohio Medical Recorder*.

GLEANINGS FROM EXCHANGES.

CURE OF TRIGEMINAL NEURALGIA BY ACONITIA.—Dr. R. F. Weir (*Archives of Medicine*, vol. ii., 1879, p. 210) had under his care a patient who had suffered with severe neuralgia for eighteen years, affecting principally the distribution of the infraorbital nerve of the left side of the face, with the paroxysm recurring nearly every minute. Sleep was obtained by the use of chloral and opium. Half an inch of the nerve was removed, and the relief thus gained lasted three or four months, when it recurred and became more marked in the parotid and upper temporal regions, and along the teeth of the upper jaw as well as the lower. Aconitia was administered in doses of $\frac{1}{10}$ gr. increased to $\frac{1}{5}$ gr. ter die. After the second dose of this strength the patient felt slight coldness over the body, with moderate tingling sensations. No effect on the neuralgia was, however, noticed, and two days later four doses of $\frac{1}{10}$ gr. each were given without any physiological effect, though the pain was made easier, so much so that the patient slept the next night without any anodyne. At the end of eight days the dose of aconitia had been increased to $\frac{1}{5}$ gr. seven times a day, no physiological effects, excepting occasional slight chilliness, having been produced. The amelioration of pain was most marked. The aconitia was then stopped. A note made five weeks later states that no recurrence of the neuralgia had taken place; only occasional slight twinges were observed.

PUSTULAR INFLAMMATION OF THE VAGINA.—Dr. G. Ernest Herman (*Obstetrical Jour. Great Britain and Ireland*, vol. vii., No. 4, 1879). A woman of 27, with a history pointing towards former syphilitic trouble, complained of a profuse, thick, yellow discharge from the vagina. On digital examination, the vagina was found studded with shot-like elevations, more numerous at its upper portion, where they coalesced. With the speculum, these were found to be composed, in part, of papular elevations, smooth, round, and yellow in the centre, as though containing pus; some presented on their summits crater-like depressions, lined or bordered with yellowish-white, seemingly pustules which had burst; and some were simply small, superficial ulcers. Between these diseased parts the nearly healthy mucous membrane could be seen, slightly injected. The vaginal portion of the cervix uteri was red and raw-looking. The os and vagina contained a thick, yellow, glutinous discharge. Pustules had been present upon the cervix uteri. The patient was ordered the following:

R Magnesii sulphat., 3ss;
Liquor. ammoniae acetat., 3ii;
Aquaæ, ad 3i.—M.
To be taken thrice daily.

The vagina was syringed with a lotion of sulphate of zinc, three grains to the ounce. Later, strong carbolic acid was applied to the cervical canal, and a glycerin plug was inserted into the vagina. A cure was finally obtained, after a month or two. [The affection was evidently not syphilitic.—ED.]

THE TREATMENT OF HEMORRHOIDS.—Dr. F. P. Atkinson (*Practitioner*, August, 1879, p. 105) thinks enough has not been said relative to the local (non-operative) treatment of hemorrhoids. He divides the affection into three classes, —acute, subacute, and chronic. In the acute stage, when they are of a dark-red appearance, and give rise to a throbbing, burning pain, the effect of calomel dusting is something wonderful. Sponging with hot water also gives a good deal of ease. If this prove ineffectual, and the pain is excessive, leeches may be applied to the anus, or an incision made into the centre of the swelling and the contents squeezed out. In the subacute stage the feeling is more of weight and tension, although it is often acute on going to stool. Compound gall ointment or solution of acetate of lead and opium should be freely and frequently applied, with enema of cold water after each stool. In the chronic stage, the best application is the common pitch ointment; old women sometimes apply a tarred rope. Its astringent effect is something remarkable. Dr. Atkinson recommends, internally, confection of senna or a pill containing euonymus at night, with effervescent Carlsbad salts in the morning.

OBSERVATIONS ON THE DIGESTION OF MILK.—Under this heading, Dr. E. F. Brush (*N. Y. Med. Jour.*, 1879, p. 300) gives the result of some experiments which he has made in the digestion of milk and kumyss. Cows' milk, he says, is not so digestible as the milk of mares, etc., because the cow is a cud-chewing animal. In kumyss the caseine is, so to speak, practically regurgitated and chewed, *i.e.*, having been coagulated, it is re-subdivided, and incapable of being coagulated under any acid or ferment. An advantage of kumyss in the artificial feeding of children is that the sugar of the milk has been changed into alcohol instead of lactic acid, alcohol, when properly presented, being in reality a hydrocarbonaceous food. Dr. Brush subsisted for a number of days on kumyss exclusively, taking eight bottles a day. During this time his urine, carefully examined, contained no alcohol. Afterwards, distilling some kumyss, he drank the distillate, and, later, discovered alcohol in his urine. This goes to show that alcohol, as contained in kumyss, is destroyed in the system, but the same alcohol, when it has undergone the process of distillation, is eliminated as alcohol.

HOT-WATER INJECTIONS IN ABORTION.—Dr. Arthur Perigal (*Lancet*, ii., 1879, p. 276) was called to see a woman in abortion, with severe flooding. After using ergot without

result, water, as hot as could be borne, was injected, and, the bleeding having somewhat abated, the fragments of the placenta were taken away, and by the aid of further doses of ergot, aromatic sulphuric acid, and cinchona, the patient made a good recovery.

NITRITE OF AMYL IN SEA-SICKNESS.—Mr. Henry Naylor (*Lancet*, ii., 1879, p. 276) says, with regard to the cause of sea-sickness,—

"The theory I propose may be called the cerebral anæmic theory. The rapid swinging of the vessel and the body with it irritates the eyes and vision, and this, by reflex action, produces a spasm of the cerebral capillaries; this explains the feeling of faintness and giddiness that comes on suddenly just as the vessel gives a big swing. The sudden emptying of the cerebral vessels causes the stomach to sympathize, resulting in efforts of vomiting, whether the stomach be full or empty. These symptoms are most distressing when the subject is in a standing or sitting position, with the eyes open. If he lies down, the change of position relieves the anæmia, the faintness and giddiness pass off, and the sickness ceases. But occasionally even the recumbent position does not give relief if the eyes are kept open. When they are shut, the symptoms are not felt in the least. I have known this to be the case with several ladies, who were never comfortable while at sea unless they were lying down with their eyes closed. They were able to eat meals and retain them if they lay down and closed their eyes immediately afterwards. In fact, I have been obliged to keep some constantly in bed to prevent their dying of starvation. A fact that helps to show the feasibility of the anæmic theory is that brandy and other stimulants give considerable relief for a time, which would not be the case if cerebral congestion had to do with sea-sickness. The explanation of how sea-sickness continues so persistently in some is that the sickness weakens the heart's action, and this keeps up the cerebral anæmia, and that in turn again produces the sickness; so that prolonged sea-sickness is due to a circuit of causes, the one producing the other,—the visual irritation, cerebral anæmia, sickness, weak heart's action.

"With reference to nitrite of amyl, if it is to do any good it must do so at once. This is because the medicine, being an antispasmodic, relieves the spasm of the cerebral vessels, and thus the brain is refilled with blood. But if it fails, then the persistent sickness, by its effect on the contractions of the heart, prevents the brain from getting a sufficient supply of blood, and thus the brain becomes anæmic, not from a spasm of the capillaries, but from an insufficient power of the heart. It is at this stage that alcoholic stimulants, in small doses frequently repeated, give great relief."

ANTISEPSIS IN MIDWIFERY.—In the lying-in asylum of Copenhagen the influence of anti-

septics in midwifery has been thoroughly tested.

"During twenty-two years (1822 to 1843), 21,149 women were confined there, of whom 1096 died of puerperal fever, or 1 in 19. Influenced by the remarkable results obtained in the surgical service by the adoption of Lister's method of operating and of dressing wounds, Stadfeldt, the physician-in-chief, introduced a strict preventive antiseptic treatment. A small room is set apart for deliveries, and from two to six hours after delivery the patient is brought, in the bed in which she has been delivered, into one of the rooms opening on the other part of the corridor. Inasmuch as the establishment is a school for the training of midwives, the pupil goes with her patient from the delivery apartment to the lying-in department, and when the patient leaves the nurse takes a bath and her body and clothes are disinfected in the following way. Connected with the window of a small room is a *hose* of sufficient size to cover the head, allowing space for free respiration, while her person and clothes are subjected, for a quarter of an hour, to the fumes of sulphurous acid. Before and after digital examination per vagina, the hands are washed with a solution of carbolic acid, and all instruments used in operation are disinfected in this carbolized water. If possible, the confinement takes place under a spray of the same disinfectant; vaginal injections with carbolized water (one pint to one hundred and twenty-five) are used in every patient twice a day; all lesions are dressed with carbolized ointment, and the external genitals covered with carbolized oil, which, of late, has been replaced with salicylic acid in ten parts of wheat flour, powdered over the parts two or three times daily. The patient rests on a sack filled with chaff, both sack and contents being burned when the patient is discharged. Each patient is allowed a pillow of hair, and also blankets, and if the delivery has been attended with anything abnormal, these articles are thoroughly cleansed. The room remains empty after each confinement, and is often disinfected. The same bed-pans, syringes, and catheters are never used for the sick and the well. The water-closets are disinfected every day. The after-births and soiled clothes are immediately thrown into a pail containing a strong solution of chlorinated lime, and burned the next morning.

"This treatment has accomplished all that was expected of it. During the twenty years from 1850 to 1869 inclusive there were 21,675 deliveries, of whom 815 died of puerperal fever, or 1 in 26, while during the five years from 1870 to 1874 inclusive, in which special attention was directed to antisepsis, there were 5304 deliveries, with 61 deaths from puerperal fever, or 1 in 87, the highest mortality being 1 in 75, the lowest 1 in 170."—Dr. Lothrop, in *Buffalo Medical and Surgical Journal*, 1879, p. 49.

INCISION IN DYSMENORRHEA.—Dr. Fordyce Barker, at the late meeting of the American Gynaecological Society, remarked that this operation had been performed unnecessarily and injudiciously. He was cognizant of sixteen deaths which had followed this method of treatment in the hands of skilful surgeons. He had himself seen over a hundred cases in which no relief had followed this operation. Dr. T. Addis Emmet said he believed firmly that mechanical dysmenorrhœa was a myth. Where such an operation is contemplated, he urged strongly the searching for the results of a previous cellulitis.—*Toledo Medical and Surgical Journal*.

RUSSIAN GARGLE.—Carbolic acid and tannic acid, each fifteen parts; alcohol, sixty parts; distilled water, one hundred and twenty parts. A teaspoonful of this is added to half a pint of water in order to form the gargle. This solution is largely employed in Russia at the commencement of angina and in chronic inflammations of the throat.—*L'Union Méd. ; Med. Times and Gazette*.

ACUTE BRIGHT'S DISEASE CURED BY JABORANDI.—Prof. J. M. Da Costa, in the *Hospital Gazette*, publishes a clinical lecture, in the course of which he records a case of acute nephritis cured by this drug. The fluid extract of jaborandi was used in drachm doses three times daily. This dose produced excessive diuresis and diaphoresis. At the expiration of five days all symptoms of the disease had disappeared. The woman was left in an extremely prostrated condition, to counteract which *dialyzed* iron was administered both internally and hypodermically.—*Brief.*

IMPROVED METHOD OF APPLYING HEAT TO THE CHEST.—Dr. Thomas J. Mays (*N. Y. Med. Jour.*, October, 1879, p. 365) says that the essential points of utility in a poultice are, 1, a capacity to retain a moderately hot and constant temperature; 2, sufficient extension to envelop not only the inflamed but also the surrounding healthy parts. In order to fulfil these indications in a more satisfactory manner, particularly in the treatment of chest troubles, Dr. Mays has devised a double-vest-shaped jacket of rubber. This is fitted with rubber tubes to admit and discharge the steam, which is generated in a cylindrical boiler of tin, eight inches in diameter, six inches high, and holding two gallons of water (two-thirds of which quantity is sufficient for steaming purposes). This may be placed on the stove or a small portable gas or kerosene furnace. This jacket, made by Tiemann & Co., of New York, is pictured in Dr. Mays's article, and seems admirably adapted to all those uses for which a poultice is ordinarily applied. Steam may be admitted to either side alone or to both together. A thick vest of flannel should be interposed between the steam vest and the skin, and it may be used while the patient is sitting up or in bed.

EFFECT OF DIFFERENT REMEDIES IN

ASTHMA.—A man suffering from spasmodic asthma was given during a paroxysm an inhalation of ten drops of the iodide of ethyl, but without relief. Nitrite of amyl was subsequently used, but without benefit. Emetic doses of ipecac relieved the paroxysms for half an hour, but they then returned as severe as before. Iodide of potassium, one hundred and eighty grains daily, proved useless. The same result followed bromide of potassium, one hundred and twenty grains daily. Quinine, fifteen grains morning and evening, caused slight relief, but the cinchonism which followed required its suspension. One effect of the quinine was to cause profuse watery discharge from the nose. Tincture of belladonna fifteen drops and carbonate of sodium ten grains, lessened the cough of the concurrent bronchitis. The attacks became less frequent, but were equally severe. The only decided benefit in the case was from the use of hypodermics of morphia. They never failed.—Report of Mount Sinai Hospital, *New York Medical Journal*, October, 1879, p. 409.

MISCELLANY.

HARD ON THE SPECIALISTS.—Dr. L. P. Yandell, of Louisville, known among dermatologists as the author of a theory of malaria as the cause of many skin diseases, which has failed to gain the support hoped for by its talented originator, thus relieves himself in a letter describing the recent meeting of the British Medical Association :

"I forgot to mention, while speaking of the dermatological section, that in the discussion of lupus it transpired that Anderson, Morris, Squire, Hutchinson, Walter Smith, Stowers, and Thire all considered this disease a form of scrofula. This doctrine I have taught in the University. After a while they will all come to recognize psoriasis and ichthyosis also as scrofula. When dermatologists get to studying and treating diseases with reference to their cause, then the science will advance rapidly in simplicity and usefulness. There is little to hope in this direction from the young specialist, who, like the parasites of this membrane, never goes deeper than the three layers of this wonderful corporal envelope. It is to the all-around man, who sees the skin as a part of a whole, which is nourished and diseased in the same way that other portions of the body are, that the profession must look for practical instruction."

EXTREME MEASURES.—Dr. R. L. Payne, of North Carolina, is an advocate of the heroic treatment of the too prevalent custom of kissing. He would abolish it altogether. To him *kiss* no longer, as in the golden age, rhymes with *bliss*, but with *syphilis*. After citing some cases of labial chancre, the doctor says,—

"Very many other diseases may be con-

veyed by the act of kissing, and I might go on at length enumerating them, and adducing 'confirmations as strong as proof of Holy Writ'; but my object is simply to call attention to the truth which lies in this direction, and to testify most solemnly against a practice so fraught with danger, so pregnant with death!

"The act of kissing is never, under any circumstances, indispensable (*sic!*), and the indiscriminate practice is not only unnecessary, but is also foolish, dangerous, and very often insincere.

"Ah, yes; many an insidious kiss has been given since the days of Judas! Then, why longer indulge in a custom so empty, so meaningless, but yet so potent for evil?"

ANTI-VIVISECTION IN ENGLAND.—The feeling against vivisection in England has been stirred up till it has become dangerous to scientific interests as well as absurd from every sensible point of view. A bill was finally presented in Parliament for the total abolition of vivisection, and it was strongly urged from some quarters. It has recently received a quietus, however, being defeated in both houses. The vote in the House of Lords was eighty-one to sixteen.—*New York Medical Record.*

QUININE, SOLUTION OF, IN STOMACH.—A weak tartaric acid lemonade taken after quinine is said to hasten solution and absorption, and relieves gastric irritability.

UNFORTUNATE AND UNEXPECTED RESULT OF THE "HIGHER EDUCATION OF WOMEN."

—Miss Emilie Lawson is a medical student of the Pacific coast who occasionally "drops into poetry." The following specimen of her versification is part of an address to her fellow-students of the Celsian Association of the Medical College of the Pacific. After alluding, in the course of a general survey of the universe, to the "patient, wise foraminifera" as "cunning dears," the poetess goes on to apostrophize her auditors in the usual strain, and ends thus:

"To-night we kindle our ambitious flame,
Whose glowing fires shall burn from age to age,
Fed by the wisdom of the coming sage,
Till the bright clouds, in luminous flakes uncurled,
Shall float in shining fragments o'er the world."

THE ERASMUS WILSON TRUST.—It is generally known that the chair of Dermatology in the Royal College of Surgeons, established and filled by Mr. Wilson, has now been abolished at the instance of the donor. Mr. Wilson has now, in place of it, founded a trust to promote original research in pathology by members of the College of Surgeons, and the publication of the results of such research by lectures, to be delivered in the college. The lecturer receives the usual honorarium of twenty-five dollars per lecture, and further remuneration according to the value of the research and the expense incurred for it.

PROF. BRÜCKE, who has held the chair of Physiology in the University of Vienna since 1849, has been chosen Rector Magnificus for 1879-1880, being the first Protestant rector from the foundation of the university.

THERE were in Saxony, in 1878, 1126 suicides,—a decided increase. 215 were women.

THE new London Temperance Hospital, it is said, will cost \$150,000.

BADEN-BADEN baths had 31,461 visitors this summer; Carlsbad, 21,019; Aix-la-Chapelle, 15,447.

SURGEON-GENERAL UNITED STATES NAVY.—Philip S. Wales, M.D., who has been appointed Chief of the Bureau of Medicine and Surgery of the United States Navy, with the relative rank of commodore, to succeed Chief (Surgeon) J. Winthrop Taylor, placed on the retired list, was born in Annapolis. He received his primary education in the high school of Baltimore, and subsequently studied medicine under the tutelage of the late Professor Dunbar, and graduated, in the spring of 1856, at the medical school of the University of Maryland. Dr. Chatard, now Bishop of Vincennes, Ind., was one of his classmates. He was commissioned an assistant-surgeon in the navy, April 17, 1856, and was soon ordered to duty at the Naval Academy, Annapolis. On June 8, 1873, he was promoted to be a medical inspector, and at the time of his new appointment had reached nearly the top of the list of the fifteen medical inspectors in the service. Dr. Wales is about forty-five years of age, and carries with him a most excellent reputation into the high office he has been called to fill.

THE Société de Biologie in Paris has opened a subscription-list for the purpose of erecting a monument to Claude Bernard. It will take the form of a statue, which, by permission of the Municipal Council of Paris, will be placed opposite the chief entrance of the Collège de France.

THE new catalogue of the library of the Faculty of Medicine in Paris, which has been nearly two years in preparation, has been recently completed, and the books have been arranged in order on the shelves. The library contains from 55,000 to 59,000 volumes, more than 20,000 of which had been lying for years, covered with dust, in obscure places.—*Hospital Gazette.*

ACONITE-POISONING.—Dr. C. G. Carleton reports a case of aconite-poisoning from about three teaspoonfuls tincture of the root, with recovery. Four hypodermic injections, fifteen drops each, of tincture of digitalis were given.—*British Medical and Surgical Journal*, 1879, 545.

BERGH VERSUS MAGENDIE.—"At the head of barbarous and unfeeling vivisectors stand the French and Italians, the Austrians and Germans next, and lastly the English. The wretch Magendie, before alluded to, was undoubtedly the most abandoned criminal that

ever lived. Where the pitiless deeds of our own countrymen will ultimately rank them in this damnable record, time will show."

THE effects of anaesthetics are remarkable in most quarters of the globe, but in New York City a frightful danger lurks in the ether bottle. Woe to the matron or the maiden that comes within its influence. A woman in that city avers that a dentist violated her during anaesthesia, and that in due time she was relieved, at his suggestion, of the fruits of his work by an abortionist. All of which our esteemed contemporary the *Hospital Gazette* thinks may be of the nature of a subjective sensation. Perhaps; but outside of New York subjective beginnings do not lead to such objective results.

DR. SETH W. WILLIAMS, senior assistant in Bellevue Hospital, recently died of the very rare disease idiopathic cerebral abscess.

METHOD FOR THE DISCOVERY OF SPERMATOZOA IN URINE.—M. Rouvier allows the urine to stand for twelve hours, adding benzine in summer to prevent putrefaction; he then decants it and collects the flocculent precipitate. This precipitate is put into a test tube, ether is added, and the mixture is well shaken. In a few minutes the ether collects on the surface of the liquid as a gelatinous layer. The ether is removed by means of a pipette, and is placed in a conical glass containing a small quantity of distilled water. All the spermatozoa in the urine thus tested are found in a very small compass, and each microscopic preparation will contain at least five or six in the field.

—*Gaz. Hebdomadaire.*

THE purgative effect of hypodermic injections of aloin has been investigated by Dr. Frohmüller, who states that a solution of one part of aloin in twenty-five parts of very warm water will have the same purgative effect when injected hypodermically as when taken internally. Two injections are usually necessary to produce the desired effect in from six to fourteen, very rarely in two to three, hours, there being scarcely any irritation and never an abscess caused where injected. Hypodermic injections with extract of aloes (one part in ten parts of water) also proved efficacious, but produced a stronger inflammation, where injected, than aloin. —*Pharm. Post; Am. Jour. of Pharmacy.*

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY FROM OCTOBER 5 TO OCTOBER 18, 1879.

SUTHERLAND, CHARLES, COLONEL AND SURGEON.—To report in person to the Commanding General, Military Division of the Pacific, for duty as Medical Director of that Division. S. O. 229, A. G. O., October 4, 1879.

IRWIN, B. J. D., MAJOR AND SURGEON.—To report in person to the Commanding General, Department of Dakota, for assignment to duty. S. O. 229, c. s., A. G. O.

WOLVERTON, W. D., MAJOR AND SURGEON.—To report in person to Commanding General, Department of Dakota, for assignment to duty. S. O. 229, c. s., A. G. O.

HORTON, S. W., MAJOR AND SURGEON.—To proceed from Omaha, Neb., to Rawlins, Wy. T., and report in person to the Department Commander. S. O. 91, Department of the Platte, October 11, 1879.

GIBSON, J. R., MAJOR AND SURGEON.—At expiration of his present leave of absence, to report in person to the Commanding General, Department of the East, for assignment to duty. S. O. 235, A. G. O., October 13, 1879.

BROWN, H. E., CAPTAIN AND ASSISTANT-SURGEON.—Leave of absence extended one month. S. O. 111, Division of the Missouri, October 13, 1879.

TAYLOR, M. K., CAPTAIN AND ASSISTANT-SURGEON.—To accompany second detachment of the Fourth Cavalry from Fort Clark to Fort Hays, Kans., and return to proper station upon completion of this duty. S. O. 211, c. s., Department of Texas.

VICKERY, R. S., CAPTAIN AND ASSISTANT-SURGEON.—Assigned to duty at Fort D. A. Russell, Wy. T. S. O. 92, Department of the Platte, October 11, 1879.

MIDDLETON, P., CAPTAIN AND ASSISTANT-SURGEON.—Assigned to temporary duty as Post-Surgeon at the post of San Antonio, Tex. S. O. 211, Department of Texas, October 7, 1879.

KIMBALL, J. P., CAPTAIN AND ASSISTANT-SURGEON.—Confirms order of October 1, 1879, directing him to proceed to Rawlins, Wy. T., for duty in the field. S. O. 91, c. s., Department of the Platte.

MUNN, C. E., CAPTAIN AND ASSISTANT-SURGEON.—To report in person to the Commanding General, Department of the Missouri, for assignment to duty. S. O. 232, A. G. O., October 9, 1879.

DE WITT, C., CAPTAIN AND ASSISTANT-SURGEON.—Confirms order of October 1, 1879, directing him to proceed to Rawlins, Wy. T., for duty in the field. S. O. 91, c. s., Department of the Platte.

BYRNE, CHARLES B., CAPTAIN AND ASSISTANT-SURGEON.—Relieved from duty in Department of Texas, to proceed to New York City, and, on arrival, report by letter to the Surgeon-General. S. O. 235, c. s., A. G. O.

MOSELEY, E. B., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Having reported in person, relieved from duty at Fort Robinson, Neb., and to report in person to the Department Commander at Rawlins, Wy. T. S. O. 89, Department of the Platte, October 6, 1879.

FINLEY, J. A., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Granted leave of absence for four months. S. O. 230, A. G. O., October 6, 1879.

TURRILL, H. S., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Relieved from duty at Fort Columbus, New York Harbor, and assigned to duty at Madison Barracks, Sackett's Harbor, N.Y. S. O. 182, Department of the East, October 16, 1879.

COMEGRYS, E. T., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Relieved from operation of par. 7, S. O. 210, c. s., from these Headquarters. S. O. 211, c. s., Department of Texas.

KILBOURNE, H. S., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—To report in person to Commanding General, Department of the East, for assignment to duty. S. O. 235, c. s., A. G. O.

BIART, VICTOR, FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Relieved from duty at the Cantonment on North Fork of the Canadian River, Ind. T., and to take post at Fort Leavenworth, Kans. S. O. 193, Department of the Missouri, October 4, 1879.

BIART, V., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Granted leave of absence for one year on Surgeon's certificate of disability, to take effect October 1, 1879, with permission to go beyond sea. S. O. 232, c. s., A. G. O.

APPEL, A. H., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—To repair to Fort Benton, M. T., and to report to the Post-Commander for duty as Post-Surgeon. S. O. 106, Department of Dakota, September 30, 1879.

PHILLIPS, H. J., CAPTAIN AND ASSISTANT-SURGEON.—Died at New York City on October 10, 1879.